AMENDED IN SENATE MAY 10, 2001

AMENDED IN SENATE MARCH 26, 2001

SENATE BILL No. 455

Introduced by Committee on Insurance (Senators Speier (Chair), Escutia, Figueroa, Johnson, Oller, Scott, and Soto)

February 22, 2001

An act to repeal and add Section 2417 of the Business and Professions Code, to amend Section 1383.15 of the Health and Safety Code, and to amend Section 10192.55 of, and to add Section 10232.65 to, the Insurance Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 455, as amended, Committee on Insurance. Health care.

(1) The Medical Practice Act provides that any type of business organization that holds itself out to the public as an organization practicing medicine, or that a reasonably informed person would believe is engaged in the practice of medicine, shall only be owned and operated by one or more licensed physicians and surgeons, except as otherwise provided, and further provides that a physician and surgeon who knowingly practices medicine with a business organization in violation of this requirement shall have his or her license to practice permanently revoked by the Medical Board of California.

This bill would repeal this provision of the Medical Practice Act.

This bill would require the Department of Insurance to report, *based on evidence,* to the appropriate regulatory agency, a suspected violation by physicians and surgeons, and organizations being operated in violation of provisions governing clinics, professional corporations, and physicians and surgeons, relative to potential insurance fraud. The

bill would require the appropriate regulatory agency, upon receiving a report from the department, to conduct an investigation. The bill would also require the permanent revocation of the license of a physician and surgeon who practices medicine with a business organization that is in violation of the above provisions.

(2) Existing law requires under specified circumstances that a health care service plan provide or authorize a 2nd opinion by an appropriately qualified health care professional. Existing law defines an ''appropriately qualified health care professional'' as a primary care physician, specialist, or other health care provider acting under certain conditions.

This bill would delete health care providers other than primary care physicians and specialists from that definition except for specialized health care service plans.

(3) Existing law, with regard to Medicare supplement insurance policies, provides that all insurers, brokers, agents, and others engaged in the business of insurance owe a policyholder a duty of honesty, and a duty of good faith and fair dealing.

This bill would provide that these duties are also owed to prospective policyholders.

(4) Existing law, with regard to Medicare supplement insurance policies, imposes limitations on the amount of premiums that may be collected by an issuer of a policy prior to the time that the policy is delivered to the applicant, and imposes other related requirements.

This bill would provide that these provisions also apply to insurers that issue long-term care insurance policies.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 2417 of the Business and Professions Code is repealed.

SEC. 2. Section 2417 is added to the Business and Professions Code, to read:

2417. (a) If the Department of Insurance ~~believes~~ *has evidence* that a business is being operated in violation of this chapter, Part 4 (commencing with Section 13400) of Division 3 of the Corporations Code, or Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code, ~~relative to a~~

~~potential violation~~ *and that the business may be in violation* of Section 1871.4 of the Insurance Code or Section 549 or 550 of the Penal Code, then the department shall report the business ~~entity~~, and any physician and surgeon suspected of knowingly providing medical services for that business relative to a violation of Section 1871.4 of the Insurance Code or Section 549 or 550 of the Penal Code, to the appropriate regulatory agency. Upon receiving a report from the Department of Insurance of a suspected violation, the regulatory agency shall conduct an investigation. The requirement in subdivision (a) of Section 1872.95 of the Insurance Code for investigations to be conducted within existing resources does not apply to investigations required by this section. The Department of Insurance may consult with the appropriate regulatory agency prior to making its report to that agency, and this consultation shall not be deemed to require the agency to conduct an investigation.

(b) A physician and surgeon who practices medicine with a business organization knowing that it is owned or operated in violation of this chapter, Part 4 (commencing with Section 13400) of Division 3 of the Corporations Code, or Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code shall have his or her license to practice permanently revoked.

SEC. 3. Section 1383.15 of the Health and Safety Code is amended to read:

1383.15. (a) When requested by an enrollee or participating health professional who is treating an enrollee, a health care service plan shall provide or authorize a second opinion by an appropriately qualified health care professional. Reasons for a second opinion to be provided or authorized shall include, but are not limited to, the following:

(1) If the enrollee questions the reasonableness or necessity of recommended surgical procedures.

(2) If the enrollee questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.

(3) If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the enrollee requests an additional diagnosis.

(4) If the treatment plan in progress is not improving the medical condition of the enrollee within an appropriate period of time given the diagnosis and plan of care, and the enrollee requests a second opinion regarding the diagnosis or continuance of the treatment.

(5) If the enrollee has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

(b) For purposes of this section, an appropriately qualified health care professional is a primary care physician or specialist who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion. For purposes of a specialized health care service plan, an appropriately qualified health care professional is a licensed health care provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

(c) If an enrollee or participating health professional who is treating an enrollee requests a second opinion pursuant to this section, an authorization or denial shall be provided in an expeditious manner. When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to the enrollee's ability to regain maximum function, the second opinion shall be authorized or denied in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the request, whenever possible. Each plan shall file with the Department of Managed Health Care timelines for responding to requests for second opinions for cases involving emergency needs, urgent care, and other requests by July 1, 2000, and within 30 days of any amendment to the timelines. The timelines shall be made available to the public upon request.

(d) If a health care service plan approves a request by an enrollee for a second opinion, the enrollee shall be responsible

only for the costs of applicable copayments that the plan requires for similar referrals.

(e) If the enrollee is requesting a second opinion about care from his or her primary care physician, the second opinion shall be provided by an appropriately qualified health care professional of the enrollee's choice within the same physician organization.

(f) If the enrollee is requesting a second opinion about care from a specialist, the second opinion shall be provided by any provider of the enrollee's choice from any independent practice association or medical group within the network of the same or equivalent specialty. If the specialist is not within the same physician organization, the plan shall incur the cost or negotiate the fee arrangements of that second opinion, beyond the applicable copayments which shall be paid by the enrollee. If not authorized by the plan, additional medical opinions not within the original physician organization shall be the responsibility of the enrollee.

(g) If there is no participating plan provider within the network who meets the standard specified in subdivision (b), then the plan shall authorize a second opinion by an appropriately qualified health professional outside of the plan's provider network. In approving a second opinion either inside or outside of the plan's provider network, the plan shall take into account the ability of the enrollee to travel to the provider.

(h) The health care service plan shall require the second opinion health professional to provide the enrollee and the initial health professional with a consultation report, including any recommended procedures or tests that the second opinion health professional believes appropriate. Nothing in this section shall be construed to prevent the plan from authorizing, based on its independent determination, additional medical opinions concerning the medical condition of an enrollee.

(i) If the health care service plan denies a request by an enrollee for a second opinion, it shall notify the enrollee in writing of the reasons for the denial and shall inform the enrollee of the right to file a grievance with the plan. The notice shall comply with subdivision (b) of Section 1368.02.

(j) Unless authorized by the plan, in order for services to be covered the enrollee shall obtain services only from a provider who is participating in, or under contract with, the plan pursuant to the specific contract under which the enrollee is entitled to

health care services. The plan may limit referrals to its network of providers if there is a participating plan provider who meets the standard specified in subdivision (b).

(k) This section shall not apply to health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements if, subject to all other terms and conditions of the contract that apply generally to all other benefits, access to and coverage for second opinions are not limited.

SEC. 4. Section 10192.55 of the Insurance Code is amended to read:

10192.55. (a) With regard to Medicare supplement policies, all insurers, brokers, agents, and others engaged in the business of insurance owe a policyholder or a prospective policyholder a duty of honesty, and a duty of good faith and fair dealing.

(b) Conduct of an insurer, broker, or agent during the offer and sale of a Medicare supplement policy previous to the purchase is relevant to any action alleging a breach of the duty of honesty, and a duty of good faith and fair dealing set forth in subdivision (a).

SEC. 5. Section 10232.65 is added to the Insurance Code, to read:

10232.65. In addition to any other requirements of law, the following shall apply to a long-term care insurance policy:

(a) The insurer shall not require an amount greater than one month's premium to be submitted with an application for the policy of insurance if interim coverage is not provided. If interim coverage is provided, the insurer shall not require an amount greater than two months' premium for that purpose. No further premiums may be collected until the policy is delivered to the applicant.

(b) The insurer shall notify the applicant within 60 days from the date the insurer or insurer's authorized representative or producer receives the application and the amount as to whether or not the applicant will be issued a policy of insurance. If the applicant is not so notified, the insurer or insurer's authorized representative or producer shall pay interest to the applicant on the funds that the applicant submitted with the application, at the legal rate of interest on judgments as provided in Section 685.010 of the Code of Civil Procedure, from the date the insurer or insurer's authorized representative or producer received those funds until

they are refunded to the applicant or are applied toward the premium.

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